KANSAS SUPREME COURT
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No. 06-96650-A

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**IN THE COURT OF APPEALS
OF THE STATE OF KANSAS**

BRETT AND YVONNE SHIVELY, Plaintiffs-Appellees

vs.

WESLEY MEDICAL CENTER AND LINDALL SMITH , M.D.,
Defendants-Appellants

BRIEF OF APPELLANTS
WESLEY MEDICAL CENTER AND LINDALL SMITH, M.D.;

Appeal from the District Court of Sedgwick County, Kansas
The Honorable Timothy G. Lahey, Judge, Division 8
The Honorable Karl W. Friedel, Judge, Division 1
The Honorable Anthony Powell, Judge, Division 18
District Court Case Number 06 CV 640

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NATURE OF THE CASE

This case involves the district court's grant of Plaintiff's application for a temporary injunction in relation to Brett Shively, Jr., a minor, who, at the time of the hearing on the temporary injunction, was a patient at Wesley Medical Center under the care of physician Lindall Smith, M.D. Appeal is taken from the district court's grant of the temporary injunction and the court's order forbidding necessary testing to be performed in accordance with accepted medical standards, a finding that the parents of a minor must consent to a brain viability examination before it can be performed and the court's order compelling the medical care providers to treat the child as if he were not brain dead.

ISSUES PRESENTED

1. **Do the facts and circumstances of this case fit within the recognized exceptions to the mootness doctrine where the issue of medical decision-making in regards to a brain dead child is an important public issue, it is capable of repetition with regard to this hospital and throughout the state, and it is important this court examine the issue?**

2. **Does a district court have the power to enjoin the actions and medical judgment of the health care providers of a minor patient who is believed by his physicians to be brain dead by blocking the formal testing required by accepted medical standards to determine death in accordance with K.S.A. 77-205?**

3. **Is it within the sole authority and competence of the medical profession to diagnose and declare death under K.S.A. 77-205, which requires the determination to be made in accordance with accepted medical standards?**

4. **Does a medical care provider need to obtain the informed consent of the parent(s) or guardian of a minor patient before conducting the necessary tests and examinations for a formal determination of brain-death under K.S.A. 77-205, which requires the determination to be made in accordance with accepted medical standards?**

STATEMENT OF FACTS

Brett Shively, Jr. ("Brett"), a two year-old minor, presented to Wesley's emergency room on February 4, 2006, as a result of a near drowning accident at his home. Upon his arrival at the emergency room, Brett was receiving cardiopulmonary resuscitation (CPR) from emergency medical service personnel. He had no heartbeat and no pulse. It took approximately 12 minutes in the emergency room to establish heartbeat and palpitations. (R.Vol. V at 41-42). Dr. Lindall Smith, M.D., a physician practicing in pediatrics and pediatric critical care, became Brett's attending physician following Brett's arrival to the emergency room. (R.Vol. V at 41).

When Brett was transferred from the emergency room to the pediatric intensive care unit (PICU) he exhibited some spontaneous breaths and his pupils were sluggishly

reactive to bright light. He was otherwise comatose and nonresponsive. (R.Vol. V at 42). Dr. Smith asked Dr. Subash Shah, M.D., a pediatric neurologist, to perform a consultative evaluation on Brett. (R.Vol. V at 6). Dr. Shah's initial consult was on February 5, 2006. At this time, Brett's pupils were reactive to light and he had some spontaneous reaction. (R.Vol. V at 6-7). Brett's neurological exams were "very abnormal" with no evidence of cortical (higher brain) function and minimal evidence of brain stem function; there was sluggish pupillary response. According to Dr. Shah, the prognosis was poor. (R.Vol. V at 7). For the next few days, Brett's condition remained the same, but on the evening of February 7, 2006, his condition abruptly changed. He had a sudden decrease in heart rate, blood pressure, and oxygen levels. He quit assisting the respirator. His pupils became dilated and were no longer reactive to bright light. He began to require external warming to maintain body temperature. He also developed symptoms of diabetes insipidus, a salt and water balance disorder. (R.Vol. V at 42-43; R.Vol. V at 7-8).

An MRI was performed. It showed ischemic injury to the brain and a herniation of the brain tissue crushing the brain stem at the opening of the back of the skull. (R.Vol. V at 43-44).

Dr. Shah performed an EEG, which measures electrical activity in the brain. The EEG showed no brain activity or electrocerebral signs. (R.Vol. V at 9, 44).

Dr. Smith requested Dr. Raymond Grundmeyer, a neurosurgeon, perform a consultative evaluation. (R.Vol. V at 22-23). Dr. Grundmeyer evaluated Brett while he was "normal thermic" (not hypothermic) and Brett had no sedatives on board. (R.Vol. V at 23). Dr. Grundmeyer's evaluation showed that Brett lacked pupillary response,

corneal response, a dolls eye response, gag reflex, and had no respirator response [meaning Brett was unable to breathe without the respirator]. (R.Vol. V at 24-25). These findings were consistent with brain death. (R.Vol. V at 23). Dr. Grundmeyer also testified that Brett's MRI and EEG results were consistent with brain death.[1] (R.Vol. V 25-26). There was no evidence that Brett was merely in a persistent vegetative state, as opposed to brain dead. (R.Vol. V at 28).

Drs. Smith, Shah, and Grundmeyer concurred in a recommendation of a formal Brain Viability Exam (BVE) as the final step in a determination of brain death. (R.Vol. V at 46, 9-10, 27-29). The BVE is considered to be the formal, complete exam for determining brain death. (R.Vol. V at 45-46). The BVE proposed by Brett's physicians meets the accepted medical standards for declaring death. (R.Vol. V at 21). Dr. Smith recommended to Brett's parents that a BVE be performed. (R.Vol. I at 18). Brett's parents refused to consent to a BVE, thus preventing Brett's physicians from reaching a formal diagnosis of brain death. (R.Vol. V at 8-9). Wesley's medical futility policies and procedures were then utilized to determine a course of action, which could have included transfer of care to another facility and transfer of care to another physician. (R.Vol. I. at 18; R.Vol. IV at 19-21).

On February 10, 2006, Brett's parents, the Plaintiffs, obtained a temporary restraining order, which prevented the brain viability exam from being performed. (R.Vol. I at 6-13). Dr. Smith testified that after he received the district court's temporary restraining order, he felt that he had to treat Brett as if he had brain function, even though Dr. Smith thought he probably did not. (R.Vol. V at 48).

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[1] The concept of "brain death" is discussed more fully in section II, B, *infra*. A patient who is brain dead is legally dead under K.S.A. 77-205.

On March 1, 2006, a hearing was held on Plaintiffs' application for temporary injunction. Pursuant to the district court's instruction in chambers, evidence at the hearing was restricted to the issue of the medical reason for performing a brain viability examination and what impact the results of such an examination would have upon any continued care of Brett. (R.Vol. I at 26). Although no formal diagnosis could be made, all of Brett's physicians were of the opinion that Brett was brain dead. (R.Vol. I at 26; R.Vol. V at 77). Dr. Smith testified that in order to provide the best care to his patient, he needs a complete assessment of the patient's condition; if the brain viability exam is not performed, his data is deficient and his ability to provide appropriate care is hampered. (R.Vol. V at 46). The testing required to determine whether Brett was brain dead involved only minimally invasive procedures and presented no danger to Brett. (R.Vol. V at 30-31, 67). For instance, it would have included cold coloric stimulation that looks at brain stem response, as well as an "apnea test" that looks at the patient's ability to breathe on their own off the ventilator. (R.Vol. V at 44). The apnea test involves collection of blood gases, which occurred everyday with Brett; otherwise there is no other invasive testing involved. (R.Vol. V at 67). The purpose of the studies performed in the course of a formal brain viability exam are to acquire more information about the patient's condition. (R.Vol. V at 38).

Dr. Smith also testified that he would have ethical concerns about continuing life support measures on a patient who is legally dead. (R.Vol. V at 52). Similarly, Dr. Shah testified that continuing the life support and other medical care Brett was receiving would not be appropriate for a patient that was brain dead. (R.Vol. V at 16).

Counsel for Wesley and Dr. Smith asked the district court for permission to conduct the brain viability exam unanimously desired by Brett's physicians. (R.Vol. V at 70, 72). Counsel for Wesley requested that the hearing recess with no other orders issued by the district court. (R.Vol. V at 71). Counsel for Dr. Smith argued that Brett's parents' refusal to allow the testing needed to determine whether Brett was brain dead raised ethical concerns for Dr. Smith and denied both the parents and physicians from making an informed decision as to whether Brett was dead and whether further treatment was futile. (R.Vol. V at 4).

The district court ruled that "[t]he Defendants' request for additional testing in the form of a brain viability examination is declined as the basis for such an order is not clear to the Court." (R.Vol I at 28). The district court further enjoined the Defendants from removing Brett's life support and ordered them "to provide medical care consistent with their best medical judgment concerning his condition." (R.Vol. I at 27). Finally, the district court ordered the parties to meet to develop a definitive discharge plan. (R.Vol. I at 28).

By its terms, the temporary injunction was to expire on the earlier of (a) Brett's discharge from Wesley Medical Center or (b) March 22, 2006, but the Plaintiffs were not precluded from seeking an extension of the injunction. (R.Vol. I at 27).

Pursuant to a discharge plan developed by the parties, Brett was discharged from Wesley to home care on March 17, 2006.

ARGUMENTS AND AUTHORITIES

I. This case presents an issue of statewide importance, fits within the well-recognized exceptions to the mootness doctrine, and thus should be heard and decided by this Court.

Due to Brett's release from Wesley to home health care on March 17, 2006, and the fact that he is no longer under Dr. Smith's care, it may be argued the controversy between Brett's parents and the Defendants is moot, i.e., there is no live controversy between the parties. Nevertheless, in accordance with a recognized exception to the mootness doctrine, this Court should hear and decide this case because it involves an issue of statewide importance that is capable of repetition, yet evading review.

A. The law recognizes an exception to the mootness doctrine when a case raises an issue of public importance which is capable of repetition yet evading review.

Although Kansas appellate courts do not, as a general rule, decide moot questions, there is an exception to the general rule where the case raises a question of public interest which is capable of repetition, yet evading review. *Brull v. State*, 31 Kan.App.2d 584, 586 (2003); *In the Interest of T.D.*, 27 Kan.App.2d 331, 334 (2000). This exception applies even where, as here, the parties have reached a negotiated resolution to their dispute. *See Junction City Education Ass'n v. U.S.D. No. 475*, 264 Kan. 212, 215 (1998). An example of the application of this exception occurred in *Stauffer Communications, Inc. v. Mitchell*, 246 Kan. 492 (1990) where the hearings a reporter sought to attend had ended by the time the case was considered on appeal. The parties and the court agreed the situation would recur and continue to evade appellate review. Thus, the Supreme

Court refused to dismiss the appeal as moot. *Id.* at 494 (citing *Roe v. Wade*, 410 U.S. 113, 125 (1973)).

B. The present case raises an issue of public importance which is capable of repetition, yet evading review.

This case plainly involves issues of public interest and importance. *See In re Haymer*, 450 N.E.2d 940, 946 (Ill.App.1983) (stating, in the context of deciding whether to authorize a hospital to remove minor patient who was brain dead from a mechanical ventilation system, that "the issue plainly involves matters of public concern," and refusing to dismiss the case even though it might be technically moot.). These issues include deciding who has the ultimate authority to diagnose and declare when a patient is dead and the ethical integrity of the medical profession.

Upholding the ethical integrity of the medical profession is a matter of clear public interest and concern. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (noting that, "[t]he State also has an interest in protecting the integrity and ethics of the medical profession," and upholding a state statute prohibiting assisted suicide). Courts have held that the integrity of the medical profession is an interest which should be balanced against a person's privacy right to refuse medical treatment or nutrition. *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261, 271 (1990); *State v. Narick*, 292 S.E.2d 54, 57 (W.Va.1982); *Superindendant of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425 (Mass.1977); *see also*, 22A Am.Jur.2d Death § 456.

During the hearing on Plaintiff's application for temporary injunction, Dr. Smith expressed ethical concerns about caring for a patient that may be legally dead:

> Again, given the initiating event and all subsequent studies that were done to evaluate [Brett's] neurological status if the Brain Viability Exam demonstrates brain death then there really is no decision to be made at that point in time. The patient meets my understanding of the legal definition of death by that exam and just as if the heart was no longer beating, the patient was no longer breathing, a declaration is made at a specific time and that is the end of care of that patient.
> **Q.** If the court were to order continued care in spite – I don't know if it's positive or negative finding on the Brain Viability Exam – what would you be – how will you handle that?
> **A.** Well, that's, I think, my ethical concern is that [under] acceptable medical standards we have diagnosed a patient with brain death and yet are not allowed to discontinue life support [on] basically a dead person then I have trouble with continuing those life support measures on a patient who is legally dead.

(R.Vol. V at 51-52).

Indeed, the district court's refusal to grant Brett's medical providers leave to conduct a brain viability exam and ordering them to continue life support placed the medical providers in a difficult position in relation to the American Medical Association's Code of Medical Ethics. (*See* R.Vol. IV at 78-85, setting forth the following sections in the AMA's Code of Ethics: "E-1.02, The Relation of Law and Ethics," "E-2.19, Unnecessary Services," "E-2.20, Withholding or Withdrawing Life-Sustaining Medical Treatment," "E-2.035, Futile Care," "E-2.037, Medical Futility In End-Of-Life Care,").

The present case, or one with similar facts, also involves issues which are likely to "recur and continue to evade appellate review." *Junction City Education Ass'n v. U.S.D. No. 475*, 264 Kan. 212, 215 (1998). In fact, in May 2006, Wyandotte County District Court Judge Muriel Y. Harris was presented with a dispute between the mother of a brain dead 14-year-old boy and the University of Kansas Hospital. (*See* Appendix A, district

court pleadings, newspaper articles).[2] On May 12, the boy's mother obtained a restraining order, preventing the hospital from removing life support measures. Unlike in the present case, physicians at the hospital had already diagnosed brain death by the time the restraining order was obtained. *See also*, *In re Haymer*, 450 N.E.2d 940, 946 (Ill.App.1983) (stating, in a case involving similar issues surrounding the case of a brain dead infant, that "it is readily apparent that the general issue involved in the case is likely to recur"); *Dority v. Superior Court*, 145 Cal.App.3d 273, 276 (1983) (stating, in another case involving the issues surrounding a brain dead infant, that, "[t]he novel medical, legal and ethical issues presented in this case are no doubt capable of repetition and therefore should not be ignored by relying on the mootness doctrine.").

Moreover, similar cases are likely to continue to evade appellate review. First, cases such as this frequently will be resolved out of court, but only *after* an action has been filed in district court. The physicians and other medical providers do not want to take a position adversarial to the patient's family. On the other hand, there are obvious ethical problems with continuing to treat a patient who either is, or who physicians suspect is, legally dead. Neither Wesley nor Brett's physicians felt they could reasonably object to transferring Brett to home care, and it is unlikely that medical care providers in similar circumstances would object to a patient similar to Brett being transferred out of their care and into the care of another provider. Indeed, in this case, the parties were *ordered* to work together to create a discharge plan for Brett to transition to home care.

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[2] Defendants struggled with how to properly present this material to this Court. The facts of Wyandotte County Dist. Ct. No. 06 CV 00830 show that cases presenting facts similar to the present case are "capable of repetition, yet evading review." Yet, these materials may not be properly placed into the Record on Appeal, which is only a subset of the material filed in the district court. S.C. Rule 3.01. Thus, the rules of appellate practice appear to provide no method for presenting what the Defendants consider significant material to this Court. Defendants therefore urge the Court to take judicial notice of the pleadings and material contained in Appendix A, despite the fact it is not contained in the Record on Appeal.

(R.Vol. I at 28). Factually similar cases could evade appellate review by becoming moot in a similar manner.

Cases involving brain dead patients, or cases where brain death is suspected but confirming tests are refused, are also likely to become moot as a result of intervening "cardiovascular death." *See Haymer*, 450 N.E.2d at 946 ("Evidence gained from thousands of patients studied in many centers around the world indicates that a person attached to a mechanical ventilation system who has met the brain death criteria would not be expected to maintain a heartbeat for the period of time it would take for appellate review no matter how expeditiously the appellate process proceeds . . . Thus, the situation before us is clearly a situation which is 'capable of repetition, yet evading review.'").

Finally, the appellate courts of at least three other states have heard and ruled on cases that were technically moot, but involved deciding the legal rights and duties of parties and the power of the judiciary to intervene in the context of a brain dead infant on life support. *See Dority v. Superior Court*, 145 Cal.App.3d 273, 276 (1983); *In re Haymer*, 450 N.E.2d 940, 946 (Ill.App.1983); *In re Welfare of Bowman*, 617 P.2d 731, 734 (Wash.1980) ("Although technically moot, the question presented meets all the criteria set forth in [prior case law regarding the exception to the mootness doctrine].").

This case seems as equally of "statewide importance" and "capable of repetition yet evading review" as the above cases involving a formally diagnosed brain-dead infant. The decisions of appellate courts in California, Illinois, and Washington provide strong persuasive authority for applying the exception to the mootness doctrine in this case.

II. It is within the sole competence and authority of the medical profession to diagnose and declare death; judicial intervention should be limited to a review of the procedures followed and a determination that the findings are consistent with established medical criteria.

A. Standard of Review

This case involves review of both the district court's grant of a temporary injunction and the district court's interpretation of K.S.A. 77-205, Kansas' "Determination of Death" statute.[3] The standard of review on appeal from an order granting a temporary injunction is whether the trial court abused its discretion. *Williams Natural Gas Co. v. Supra Energy, Inc.*, 261 Kan. 624, 631 (1997). However, deciding the issue of the district court's power to intervene in a physician's determination of whether a patient has died involves interpretation of a statute, namely K.S.A. 77-205, and is thus a question of law over which an appellate court's review is unlimited. *See Hamilton v. State Farm Fire & Cas. Co.*, 263 Kan. 875, 879 (1998).

B. Brain Death

Brett's treating physicians suspected that he was brain dead, although his parents' refusal to consent to a brain viability exam meant that a formal diagnosis of brain death was never reached.. Because the issues in this case involve the concept of "brain death" and how it is determined, the Defendants submit this brief overview of the concept of "brain death" and its legal recognition.[4]

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[3] The text of K.S.A. 77-205 was submitted to the district court as an exhibit via letter dated February 27, 2006. The letter and exhibits were copied to all counsel. (*See* R.Vol. I at 34-35 & R.Vol. IV at 86).

[4] Articles on brain death were submitted to the district court as exhibits in advance of the hearing on Plaintiffs' application for temporary injunction and copied to all counsel. (*See* R.Vol. IV at 1-18).

The common law traditionally recognized a cardiopulmonary definition of death – namely that once the heart and lungs have ceased operation, the individual is dead. However, it has more recently been the law's determination that brain death is the legal equivalent of death because – under current medical science – the capacity for life is irretrievably lost when the entire brain, including the brain stem, has ceased functioning. 22A Am.Jur.2d, *Death* § 422.

The Uniform Determination of Death Act (UDDA) provides that an individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards. 22A Am.Jur.2d *Death* § 422 (citing Uniform Determination of Death Act § 1).

Kansas has codified the UDDA at K.S.A. 77-205, which states:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Thus, "brain death" is defined in Kansas law as the "irreversible cessation of all functions of the entire brain, including the brain stem."

"Kansas was the first state to legislate a recognition of brain death, and made clear that it was a physician's responsibility to determine whether death had occurred." Kan.Atty.Gen.Op.No. 90-81 (July 13, 1990) (citing K.S.A. 77-202 (Weeks, 1977) ("A person will be considered medically and legally dead if, in the opinion of a physician...")); *Lovato v. Dist. Court*, 601 P.2d 1072, 1079-80 (Colo.1979).

Today, every state recognizes that death may be assessed by either cardio-respiratory or whole-brain criteria. Glazier, "'The Brain Dead Patient was Kept Alive' and Other Disturbing Misconceptions; A Call for Amendments to the Uniform Anatomical Gift Act," 9-SUM Kan.J.L. & Pub.Pol'y 640, 642 (2000).

Here, it is also critical to note the distinction between a "persistent vegetative state" (PVS) or "irreversible coma," (neither of which plays any part in the present case) and brain death, which is recognized as constituting legal death in all fifty states. A patient in a persistent vegetative state is not legally dead because their "lower brain," or brain stem, is still functioning. Brain death is total, irreversible cessation of function in *the entire brain*, including the brain stem. Thus, Brett's physicians' opinion that Brett is brain dead means that this case does not present many of the controversial issues presented in the familiar cases of Karen Ann Quinlan, Nancy Cruzan, or Terri Schiavo, who were all diagnosed to be in persistent vegetative states. *Cf. Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J.1976); *In re Schiavo*, 780 So.2d 176 (Fla.App.2nd Dist.2001). Several cases involving a brain dead infant discuss the distinction between brain death and a persistent vegetative state. *See In re Welfare of Bowman*, 617 P.2d 731, 735 (Wash.1980) ("We are not presented with the much more difficult question of whether life support mechanisms may be terminated while a person is still alive but in that condition known as a 'persistent vegetative state,' in which some brain functioning continues to exist. We are concerned here only with brain death. . ."); *Dority v. Superior Court*, 145 Cal.App.3d 273, 278 (1983); *In re Haymer*, 450 N.E.2d 940, 945 n.8 (Ill.App.1983); *Alvarado v. New York City Health & Hospital's Corp.*, 547 N.Y.S.2d 190, 195-96 (N.Y.Sup.Ct.1989).

C. The role of the courts and the medical profession in determining death

Courts have held that, while it is for the law – rather than medicine – to define the "standard" of death (i.e., what constitutes death), it is for the medical profession to determine the applicable criteria and accepted medical standards for deciding when a particular patient has actually died.

> Although the legal standard as to what constitutes death is determined by the courts or legislation, **it is the role of the medical profession to decide whether brain death or other cessation of cardiopulmonary function is present in accordance with current medical standards; judicial intervention should be limited to a review of the procedures followed and a determination that the findings are consistent with the established medical criteria. Thus, a regulation which allows physicians, rather than family members, to determine when death has occurred does not violate due process.**

22A Am.Jur.2d *Death* § 424 (emphasis added); *see also*, *Petition of Jones*, 433 N.Y.S.2d 984, 986 (N.Y.Sup.Ct.1980) ("Basically, when a patient is dead is a medical matter which should be left to the expertise of the medical profession. Judicial intervention should be limited to review of the procedures followed and a determination that the findings are consistent with the established medical criteria"); *In re Welfare of Bowman*, 617 P.2d 731, 734 & 738 (Wash.1980) (Ruling that "the law has adopted standards of death but has turned to physicians for the criteria by which a particular standard is met" and, "We do not address what are acceptable diagnostic tests and medical procedures for determining when brain death has occurred. It is left to the medical profession to define the acceptable practices, taking into account new knowledge of brain function and new diagnostic procedures"); Glazier, 9-SUM Kan.J.L. & Pub.Pol'y at 641-42 ("Defining

death is, by all accounts, multi-disciplinary . . . Diagnosing death is, in the United States, within the purview of the medical profession."). As one court has put it:

> Although the **courts have refused to establish specific criteria for a diagnosis of brain death** due to the changing nature of new technologies which could render any such criteria outdated, **they have required that a diagnosis of brain death be made in accordance with the "usual and customary standards of medical practice."** . . . How can a lay person, whether judge or juror, be expected to reach a cogent and reliable conclusion from technically complex symptoms such as these without the assistance of an expert's knowledge of the brain's function and pathology? Clearly, more than common knowledge and experience is necessary to form a correct judgment on the question of brain death.

Estate of Sewart, 602 N.E.2d 1277, 1286-87 (Ill.App.1991) (emphasis added) (holding that expert medical opinion is necessary to a determination of brain death).

1. Kansas law

As a matter of Kansas law, the Attorney General has opined that "[r]egardless of the definition of death being employed, a determination of death involves a medical diagnosis." Kan. Atty. Gen. Op. No. 90-81 (citing Abram, "The Need for Uniform Law on the Determination of Death," 27 N.Y.L.Sch.L.Rev. 1187, 1190-91 (1982)).

Furthermore, in *State v. Shaffer*, 229 Kan. 310 (1981), a defendant appealed his murder conviction based, in part, on the argument that there was insufficient evidence to establish that the victim was dead before he was removed from life support systems. *Id.* at 317. Kansas statutory law recognized brain death, *Id.* (citing K.S.A.1980 Supp. 77-202), and stated that a brain death determination was to be made when, "in the opinion of a physician, based on ordinary standards of medical practice," there was an absence of spontaneous brain function and the condition was irreversible. *Id.* The defendant contended that the phrase, "based on ordinary standards of medical practice," had to be

further defined and clarified. He urged the court to supplement the statutory definition of brain death by requiring physicians to follow the criteria developed by the Harvard Ad Hoc Committee in 1968.[5] *Id.* The court declined this form of intrusion on the province of the medical profession, stating, "[t]he phrase 'ordinary standards of medical practice' needs no further definition by this court. Further attempts to define the phrase would merely result in confusing an otherwise understandable phrase." *Id.* at 319.

The current "determination of death" statute, K.S.A. 77-205, provides that a "determination of death must be made in accordance with accepted medical standards."

Finally, Kansas law has consistently held that on questions of a medical or scientific nature only those who are qualified as experts are permitted to testify. *See Coheen v. Graber*, 181 Kan 107, 112 (1957).

In short, Kansas law makes clear that it is within the sole competence and authority of the medical profession to determine and declare when a particular patient has died. In cases of brain death especially, a district court is not qualified or equipped to make such a determination.

2. Authority from other jurisdictions

Persuasive authority from other jurisdictions, decided in the context of circumstances and issues presented by a brain dead infant, holds that while parents may be entitled to some form of "participatory" right, the diagnosis of brain death must be made by physicians in accord with accepted medical standards.

[5] The three basic criteria were (1) unresponsiveness to normally painful stimuli, (2) absence of spontaneous movements or breathing, and (3) absence of reflexes. The diagnosis of "brain death" was to be confirmed by the EEG, and was to be observed over a twenty-four hour period. 229 Kan. at 317-18.

In the situation concerning Brett Shively, there has not yet been a formal diagnosis of brain death because the parents refused to consent to the testing that would allow the physicians to make a formal diagnosis. Research has revealed no cases that have considered this precise factual scenario. There are several cases, however, that have considered factual scenarios in which, *after* a formal diagnosis of brain death has been made on a minor patient, courts have decided to authorize or order the removal of life support systems over the objections of the minor patient's parents.

In *Lovato v. District Court*, 601 P.2d 1072 (Colo. 1979), the mother and guardian ad litem of a child brought an original action to the Supreme Court of Colorado for review of a district court order directing the guardian ad litem to execute a document authorizing the child's treating physician and the hospital involved to remove all life support devices from the child if in the doctor's opinion the child was legally dead, as defined by the court. The Supreme Court of Colorado sitting *en banc*, ruled that the district court's order was proper. The primary dispute in *Lovato* involved the district court's adoption of the brain death standard without any statutory guidance from the Colorado legislature. In *Lovato*, the minor patient was discovered at his mother's apartment gagging, spitting up mucus, having difficulty breathing and unresponsive. The child had been grossly abused. He had a faint pulse. A mechanical respirator was applied. The mother was later arrested for alleged abuse of the child. *Id.* at 1073. Clinical examinations of the child revealed the following:

> He was not breathing spontaneously, and his respiration was maintained entirely by artificial means; he had no spontaneous muscular movements, no reflexes, including stretch of tendon reflexes, and no response to even the most intense pain or other stimuli; corneal reflexes were absent; his pupils were dilated and fixed, showing no response to light; there were no

> signs of voluntary physical activity, such as swallowing, blinking, yawning and pharyngeal reflexes; EEG tests were given on three separate days, each showed a complete lack of brain function.

Id. at 1074. The child's physicians testified that, while clinical and laboratory criteria used to diagnose brain death are less certain with respect to young children than to older persons, nevertheless more than sufficient time had elapsed to allow a definitive and accurate diagnosis of total and irreversible cessation of brain function. *Id.* The Colorado Supreme Court then determined that the district court's judicial adoption of the brain death standard was proper. The court reasoned:

> Prior to the development of resuscitative technology in recent decades, the medical profession went no further generally than to conclude that "when a person's heart stopped beating and he stopped breathing, he was dead . . . ." With advances, including resuscitative technology and organ transplants, the medical community has developed a more complete definition of death. There is a wealth of material describing these advances during the past ten years. The all but unanimous view endorses the concept of brain death.

Id. at 1076 (citing numerous medical and legal journal articles).

In *In re Welfare of Bowman,* 617 P.2d 731 (Wash. 1980), the Supreme Court of Washington, sitting *en banc*, upheld a lower court's ruling that because a child had suffered irreversible loss of brain activity, he was, in fact, dead. In *Bowman*, the patient, age five, was admitted to the hospital after suffering massive physical injuries inflicted by a non-family member who was caring for him. The patient's parents could not be found. The Washington Department of Social and Health Service filed a petition alleging that patient was dependent. An order was entered granting the department the authority to give consent to such medical and surgical care as was deemed necessary by the attending physician. When the natural parents were found, the order was amended to give the department and the parents joint power to authorize medical care. Later, a hearing was

held to determine whether the dependency petition should be dismissed because a parent was present and able to care for the child. The patient's guardian ad litem, who had been appointed prior to the location of his parents, resisted the dismissal on the ground that the result would be a decision by the parents to terminate the life support systems sustaining the patient. At that hearing, the testimony indicated that the patient had been unconscious since his admission to the hospital and except for a brief period of increased neurological activity, had gradually weakened. *Id.* at 732-33. The patient's physician testified that on the date of the hearing, the patient showed no brain activity. An EEG gave no reading. A radionucleide scan showed a total absence of blood flow to the brain, no cornea reflex was present and the patient's pupils were dilated and nonreactive to any stimuli. There were also no deep tendon reflexes or other signs of brain stem action, nor responses to deep pain or signs of spontaneous breathing. Body temperature and drug intake had been controlled to avoid adverse influence on these tests. *Id.* at 733. The physician also testified that all of the physicians in the hospital's intensive care unit agreed that the patient was no longer alive. *Id.* The lower court ruled that the patient was dead, but enjoined the hospital from terminating or removing life support systems for a short amount of time in order to give the guardian ad litem the opportunity to appeal to the Washington Supreme Court. The Washington Supreme Court held:

> That it is for law to define the standard of death, that the brain death standard should be adopted, and that it is for the medical profession to determine the applicable criteria – in accordance with accepted medical standards – for deciding whether brain death is present. Our action affirms the judgment of the trial court.

617 P.2d at 732. The court found that until recently the definition of death was a relatively simple matter – when the heart stopped beating and the lungs stopped breathing

the individual was dead according to physicians and according to the law. *Id.* at 734. The traditional definition did not include the criterion of lack of brain activity because no method existed for diagnosing brain death. Moreover, until recently, no mechanical means have been available to maintain heart and lung function, and respiration, heart action and brain function are so closely related that without artificial support, the cessation of any one of them will bring the other two to a halt within a short period. *Id.* The court then reviewed some of the factors that compelled a more refined definition of death and adoption of a brain death standard.

> Some of the specific factors compelling a more refined definition are: (1) modern medicine's technological ability to sustain life in the absence of spontaneous heart beat or respiration, (2) the advent of successful transplant capabilities which create a demand for viable organs from recently deceased donors, (3) the enormous expenditure of resources, potentially wasted if persons in fact dead are being treated medically as though they are alive, and (4) the need for a precise time of death so that persons who have died may be treated appropriately.

Id. at 734. The court then specifically distinguished the facts of the case it was deciding from the facts of other cases involving a patient in a persistent vegetative state.

> The specific issue in this case is whether or not [the patient] was legally dead on October 17, 1979, when the physicians declared that he had suffered brain death. We are not presented with the much more difficult question of whether life-support mechanisms may be terminated while a person is still alive but in that condition known as a "persistent vegetative state," in which some brain functioning continues to exist. We are concerned here only with whether brain death, identified as the irreversible destruction of the entire brain from which cardio respiratory death inevitably follows, is a recognized standard of death in this state.

Id. at 735.

In re Haymer, 450 N.E.2d 940 (Ill.App.1983), was another case involving a minor patient diagnosed as brain dead, but came to the courts with a different procedural

posture. The hospital sought a declaratory judgment that a seven month old patient was legally dead and requested permission to remove the patient from a mechanical ventilation system. The child's parents opposed the removal of the mechanical device, as did the child's guardian ad litem. *Id.* at 941. The trial court entered an order which provided that the legal death of the patient occurred on the date when the doctors determined that the child had suffered the total and irreversible cessation of all functions of the entire brain. *Id.* The order also authorized the hospital to discontinue the mechanical ventilation system connected to the body of the minor patient over the objections of the parents and the guardian ad litem. *Id.* The Illinois Appellate Court framed the issue:

> This case presents the issue of determining when death legally occurs in Illinois. Plainly, with the scientific and medical advances of recent years, the general and traditional definition of death, cessation of heart beat, is no longer meaningful or factually accurate. In our present day society, many people continue to live after experiencing cardiac arrest, and cardiopulmonary bypass machines permit a patient's heartbeat to cease for several hours with full clinical recovery after resuscitation.

Id. at 942 (citing medical sources). The court noted that no case has been found in which total brain death has been rejected as being the death of the person where the issue has been specifically raised. *Id.* at 943. The court then judicially adopted the language from the Uniform Determination of Death Act as the legal definition of death in Illinois. *Id.* at 945. Therefore, the court concluded that the patient was legally dead on the day his physicians had diagnosed brain death, and affirmed the order of the trial court. *Id.* at 947.

Dority v. Superior Court, 145 Cal.App.3d 273 (1983), involved a 19-day-old infant admitted to the emergency room of a hospital. The infant's parents brought him in after they noticed an odd twitching of the left arm which the doctors documented as a

seizure disorder. The attending physicians performed a variety of tests, the results of which showed increased intracranial pressure. The child was placed on a respirator. His physicians ordered tests to determine the viability of the brain. These tests, which were performed initially and then again about a month later, showed electrocerebral silence, which meant there was little if any electrical activity in the brain. The doctors concluded that the infant, having shown no signs of purposeful spontaneous activity or spontaneous respirations, was brain dead. *Id.* at 275. The hospital's policy at the time was to defer to the parent's wishes concerning the removal of life support devices in light of the emotional implications of such a decision. One doctor had testified that the hospital had kept several children on these devices for prolonged periods of time "until the parents were emotionally able to realize what the medical opinion was and what's its final impact was." *Id.* at 275-76. However, in this case, both parents chose to withhold consent to the withdraw of the life support device.[6] A trial court was petitioned to appoint a guardian in order to secure the consent of a responsible person to terminate the life support device. The court appointed the Department of Public and Social Services as temporary guardian of the child. After hearing unrefuted medical testimony that the child was brain dead, the court directed the Department to give the appropriate consent to the healthcare provider to withdraw the life support system. The parents and counsel for the minor child petitioned a California appellate court for a writ against removing the life support device. First, the court noted that California Health and Safety Code Section 7180 provided that: "Irreversible cessation of all functions of the entire brain, including the brain stem"

[6] Both parents were arrested and charged with felony child neglect or child abuse soon after bringing the child to the hospital.

constitutes death under California law. *Id.* at 277. The court next ruled that it was unnecessary for it to approve a physician's determination of brain death.

> A portion of the hearing was devoted to medical testimony which resulted in the court's declaring the infant brain dead. We find no authority mandating that a court must make a determination brain death has occurred. Section 7180 requires only that the determination be made in accordance with accepted medical standards . . . This is, and should be, a medical problem and we find it completely unnecessary to require a judicial "rubber stamp" on this medical determination. This does not mean parents or guardians are foreclosed from seeking another medical opinion. In this case, both the treating and consulting physicians agreed brain death had occurred. No medical evidence was introduced to prove otherwise. The medical profession need not go into court every time it declares brain death where the diagnostic test results are irrefutable.

Id. at 278. The trial court "can properly hear the testimony and decide whether the determination of brain death was in accord with accepted medical standards." *Id.* at 279. The court then carved out a limited right for the parents to "participate" in the decision to remove life support. The court explained:

> Parents do not lose all control once their child is determined brain dead. We recognize the parent should have and is accorded the right to be fully informed of the child's condition and the right to participate in a decision of removing the life support devices. This participation should pave the way and permit discontinuation of artificial means of life support in circumstances where even those most morally and emotionally committed to the preservation of life will not be offended. Whether we tie this right of consultation to an inherent parental right, the Constitution, logic or decency, the treating hospital and physicians should allow the parents to participate in this decision.

Id. at 279-80. The court then continued, explaining when court intervention might be necessary in such a decision.

> No judicial action is necessary where the health care provider and the party having standing to represent the person allegedly declared to be brain dead are in accord brain death has occurred. **The jurisdiction of the court can be invoked upon a sufficient showing that it is reasonably probable that a mistake has been made in diagnosis of brain death or**

> **where the diagnosis was not made in accord with accepted medical standards.** We are in accord with [the hospital's] policy of deferring to parental wishes until the initial shock of the diagnosis dissipates; and would encourage other health care providers to adopt a similar policy.

Id. at 280 (emphasis added). Thus, while the court recognized a parental right to "participate" in the decision to remove life support from a brain-dead minor, and encouraged hospitals to defer to parental wishes "until the initial shock of the diagnosis dissipates," it affirmed the lower court's order, holding that "the court's order [directing withdrawal of life support] was proper and appropriate." *Id.*

In *Alvarado v. New York City Health & Hospital's Corp.*, 547 N.Y.S.2d 190 (N.Y.Sup.Ct.1989), the parents of a brain dead infant brought an action to prevent a hospital from removing a life support system. The court held that it had no authority to intervene in the hospital's decision because the infant's condition fit within the definition of death in the relevant New York Department of Health regulation. The infant's brain ceased to function within hours of birth, although sophisticated mechanical devices maintained heart and lung function. The hospital argued that life support equipment should be withdrawn because the infant was dead. The hospital based its argument on New York Department of Health regulation 10 N.Y.C.R.R. § 400.16. That regulation defined death as it is defined in the Uniform Determination of Death Act, and additionally provided that hospitals adopt "a procedure for the *reasonable accommodation* of the individual's religious or moral objection to the determination as expressed by the individual or by the next of kin or other person closest to the individual." § 400.16(e)(3) (emphasis added). The court noted that the task force charged with developing the regulation "recommended that the regulation address

additional issues, suggesting that procedures for informing family members be developed by hospitals and that accommodation be made for religious and moral objections *without establishing a right to continued treatment*." 547 N.Y.S.2d at 195 (emphasis added). The parents contended that the regulation violated their due process rights. The court responded:

> To determine whether there has been a deprivation of a right without due process, a protected right must be established. If a person is dead, there is no life to be deprived of, with or without due process of law. **From time immemorial physicians have determined when persons are dead and have ceased giving medical treatment. . . . It is not a denial of due process to have physicians, rather than parents or next of kin or close friends, determine that death has occurred.** The state concedes that petitioners do have a protected right. They have "the right to participate in decisions concerning the medical care of family members and . . . in ensuring that necessary medical care is not improperly withheld." Under the Regulation, a hospital must have a procedure for notifying next of kin or another person closest to the individual that a determination of death will soon be completed, and the procedure for the reasonable accommodation of a religious or moral objection to the determination. In the instant case, the Alvarados were notified before a determination was made, were given an opportunity to obtain an independent medical evaluation, and were offered a chance to have the matter discussed with religious leaders and friends. Therefore, it cannot be said that the family was deprived of its due process rights to participate in the medical care of the child.

Id. at 197-98 (emphasis added). The court held that since the regulation was based on sound medical criteria and was constitutionally valid, the court had no authority to intervene. *Id.* at 198. On appeal, the court's decision was vacated with the consent of the hospital, upon the hospital's determination that the condition of the infant did not constitute brain death as it was defined in the regulation. *See Alvarado v. City of New York*, 550 N.Y.S.2d 353 (N.Y.App.Div.1990).

Finally, *In the Matter of Long Island Jewish Medical Center*, 641 N.Y.S. 2d 989 (1996), involved a hospital that sought an emergency order to show cause seeking authorization for it to withdraw artificial respiratory support from an infant that the hospital claimed was brain dead. The court held that the hospital was entitled to an order authorizing it to withdraw artificial respiratory support from a five month old infant, over the objection of the parents, where two board certified pediatric specialists and a medical expert retained by the parents certified that the child was brain dead. The court relied on the same New York Regulation discussed in the *Alvarado* case. The court also determined that the religious and moral objections of the parents had been reasonably accommodated. *Id.* at 992.

The following legal principles, distilled from the above-cited case law, will be useful in deciding the present case.

First, it is within the sole competence and authority of the medical profession to diagnose and determine death. *Bowman*, 617 P.2d at 732 ("We hold that it is for the law to define the standard of death, that the brain death standard should be adopted, and that it is for the medical profession to determine the applicable criteria – in accordance with accepted medical standards – for deciding whether brain death is present."); *Dority*, 145 Cal.App.3d at 278 ("We find no authority mandating that a court must make a determination brain death has occurred. Section 7180 requires only that the determination be made in accordance with accepted medical standards . . . This is, and should be, a medical problem and we find it completely unnecessary to require a judicial "rubber stamp" on this medical determination . . . The medical profession need not go into court every time it declares brain death where the diagnostic test results are

irrefutable."); *Petition of Jones*, 433 N.Y.S.2d at 986 ("Basically, when a patient is dead is a medical matter which should be left to the expertise of the medical profession.") (*Estate of Sewart*, 602 N.E.2d 1277, 1286-87 (Ill.App.1991) (expert medical opinion is necessary to determination of brain death)

Second, a court's power to intervene in the medical profession's determination that a particular patient is brain dead is limited to (1) circumstances where there has been a sufficient showing that it is reasonably probable that a mistake has been made in the diagnosis of brain death, or (2) ensuring that the determination of brain death was made according to accepted medical standards. *Dority*, 145 Cal.App.3d at 280 ("The jurisdiction of the court can be invoked upon a sufficient showing that it is reasonably probable that a mistake has been made in diagnosis of brain death or where the diagnosis was not made in accord with accepted medical standards."); *Bowman*, 617 P.2d at 732; *Alvarado*, 547 N.Y.S. at 198 (finding that due process was followed before declaring death and "[t]hus, the Court has no authority to intervene in what is a wrenching and heart rending decision to be made by the Hospital."); *Petition of Jones*, 433 N.Y.S.2d at 986 ("Judicial intervention should be limited to review of the procedures followed and a determination that the findings are consistent with the established medical criteria."); *Long Island Jewish Medical Center*, 641 N.Y.S.2d at 991 (following *Alvarado*, and finding "[t]here is nothing to indicate that [the physicians'] findings were anything other than 'made in accordance with accepted medical standards.'").

Third, the parents or guardians of a brain dead infant may be entitled to a reasonable accommodation of their objection to removing life support until the "initial shock of the [brain death]diagnosis dissipates." *Dority*, 145 Cal.App.3d at 280. These

accommodations may include the right to be informed of the situation, an opportunity to obtain an independent medical evaluation, and a chance to discuss the matter with family and religious or spiritual leaders. *Dority*, 145 Cal.App.3d at 279-80; *Alvarado*, 547 N.Y.S.2d at 197-98.

Fourth, the accommodations to which these parents or guardians may be entitled are procedural – not substantive – and operate "without establishing a right to continued treatment," *Alvarado*, 547 N.Y.S.2d at 195. These accommodations "should pave the way and permit discontinuation of artificial means of life support in circumstances [i.e., legal death] where even those most morally and emotionally committed to the preservation of life will not be offended." *Dority*, 145 Cal.App.3d at 279-80; *Bowman*, 617 P.2d at 738 (same). Thus, in the end, "[i]t is not a denial of due process to have physicians, rather than parents or next of kin or close friends, determine that death has occurred." *Alvarado*, 547 N.Y.S.2d at 197. This only makes sense. However heartfelt and emotionally wrought a parent's objection, the law cannot ultimately tolerate the logical absurdity of forcing medical care providers to treat and care for an individual who is legally dead. Measures wisely designed to soften the emotional impact on a parent cannot, in the end, prevent physicians from declaring a patient who meets the medically established criteria for death to be dead.

D. The district court erred when it refused to permit Dr. Smith to conduct the formal evaluation necessary to determine if Brett was legally dead and instead ordered Brett's medical care providers to continue life support and medical care as if he were alive.

Counsel for Wesley and Dr. Smith asked the court for permission to conduct the brain viability exam unanimously desired by Brett's physicians. (R.Vol. V at 70, 72).

Counsel for Wesley requested that the hearing recess with no other orders issued by the district court, so that the results could be brought back before the court before any final decisions were made. (R.Vol. V at 71). Counsel for Dr. Smith argued that Brett's parents' refusal to allow the testing needed to determine whether Brett was brain dead raised ethical concerns for Dr. Smith and denied both the parents and physicians from making an informed decision as to whether Brett was dead and whether further treatment was futile. (R.Vol. V at 4).

Nevertheless, the district court refused to grant Brett's physicians permission to conduct the formal evaluation required to determine whether Brett was brain dead and instead issued a temporary injunction ordering Wesley's nurses and the physicians, including Dr. Smith, to continue to provide life support and all medical care as if Brett were alive. (R.Vol. I at 27-28). In doing so, the court erred as a matter of law.

The law commands that the "determination of death must be made in accordance with accepted medical standards." K.S.A. 77-205. Courts therefore have a limited power to intervene in a physician's determination as to whether a particular patient has died; such power is restricted to ensuring that such a determination was made in accordance with accepted medical standards. *See Dority*, 145 Cal.App.3d at 280; *Bowman*, 617 P.2d at 732; *Alvarado*, 547 N.Y.S. at 198; *Petition of Jones*, 433 N.Y.S.2d at 986; *Long Island Jewish Medical Center*, 641 N.Y.S.2d at 991; *see also, State v. Shaffer*, 229 Kan. 310, 317 (1981) (where criminal defendant appealed from a murder conviction challenging whether there was substantial competent evidence of victim's brain death before life support was removed, death was to be determined "based on ordinary standards of

medical practice," and "[i]t was for the jury to determine whether the medical standards required had been met.").

Defendants acknowledge that the present case is distinguishable from the previously cited cases involving a brain dead minor patient. In *Bowman*, *Haymer*, *Dority*, and *Alvarado* (and the other cases from other jurisdictions cited herein), the physicians had already made a formal diagnosis of brain death before the dispute reached the court. Thus, in these cases, the parents or guardians were either (1) asking the court to prevent the removal of life support, or (2) were opposing a hospital's request to remove life support, from an infant patient *who had already been declared brain dead* by treating physicians. Nevertheless, these cases set forth legal principles and reasoning applicable to the circumstances presented by the present case.

Here, Brett's parents refused to consent to the formal evaluation required to diagnose brain death. Although each evaluation to that point had led Brett's physicians to unanimously conclude that Brett was probably brain dead, the formal evaluation procedure, which Brett's physicians felt was required by "accepted medical standards," was never conducted due to the Plaintiffs' opposition (*see* R.Vol. V at 45-46) (explaining the need for a formal exam).

The law's recognition that the authority and competence to determine death rests solely with the medical profession, however, is *meaningless* unless the law also grants physicians the power to conduct the evaluations necessary and appurtenant to that determination. Just as a district court is not competent to determine when brain death is present, it is similarly incompetent to determine when and whether it is appropriate to conduct the formal diagnostic process required to diagnose brain death. As a necessary

result, the issue of when and whether to conduct a brain viability examination should be left to the medical profession.

At the hearing on Plaintiffs' application for temporary injunction, the district court was asked by the Defendants to grant permission to conduct a brain viability exam, that is, the formal evaluation required to determine whether Brett was brain dead. This was proper because, at the time, the restraining order was still in effect. In its ruling however, the district court seemed to confuse the issues between granting *permission* to conduct a BVE and *ordering* the physicians to do the testing.[7] This confusion is first evident in how the district court framed the issues:

> Well, there are two issues before the court today. One is whether the court should continue the injunctive relief that's been granted to continue life support for Brett as is in place now. The other is whether the court should order additional testing to allow the doctors to confirm what they believe to be the case.

(R.Vol. V at 76-77). It is also apparent in the district court's ruling:

> The court's going to decline to order additional testing at this time. The basis for such an order is not clear to the court. I hope to receive additional input from the parties on the case law or something.

(R.Vol. V at 78).

The question before the district court was not whether it should "order" additional testing. There was a restraining order in place, which prevented that testing from occurring. The medical care providers made it clear that what they sought was the district court's permission to conduct that testing because according to their best medical judgment, such testing was necessary. Dr. Smith testified as follows:

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[7] The Defendants readily concede that such confusion was understandable considering the limited nature of the hearing and the emergency circumstances under which the hearing was conducted, which did not permit counsel for the parties to present evidence for the restricted hearing as thoroughly as the difficult legal issues in the case required, especially in the absence of any controlling legal authority on point.

> I believe the family and this court has petitioned me as a caring physician to provide the best clinical care. For me to do that I feel I have to have a complete assessment of this patient's condition. Short of performing this Brain Viability Exam, I have deficient data or exam findings for me to assess his condition. I feel like my ability to provide [the] appropriate and best medical care is hampered by the lack of this chronology.

(R.Vol. V at 46). Dr. Grundmeyer also testified that he recommended a formal exam (R.Vol. V at 28-29), as did Dr. Shah (R.Vol. V at 9-10). In short, the medical providers, including Wesley and Dr. Smith, *sought to lift the restraining order* and did not ask the district court to "order" them to perform the formal exam.

Thus, the correct ruling by the district court would have been to lift the restraining order currently in place, thereby granting leave to Brett's physicians to conduct the formal evaluation, which was necessary and appurtenant to the performance of their duty under the law to determine whether Brett was legally dead. Instead, the district court appeared to switch the burden of proof required at a hearing on application for temporary injunction: the burden of proof should have been on Brett's parents, who sought the injunction. *U.S.D. No. 503 v. McKinney*, 236 Kan. 224, 227 (1984); *Wichita Wire, Inc. v. Lenox,* 11 Kan.App.2d 459, 462 (1986). The issue was not "on what basis could the court order the physicians to perform such additional testing"? Rather, the issue was "on what basis could the district court continue to prevent a medical evaluation that Brett's physicians unanimously believed to be medically indicated"?[8] It is *possible* that the district court believed an order was necessary for the physicians to be able to conduct a formal exam because Brett's parents had withheld their consent. This is one reason the

[8] Defendants note that the district court expressed no similar doubts with respect to the basis of its order enjoining the Defendants from removing life support care and treatment. (R.Vol. V at 78:8-15).

Court should clarify that there was no duty to obtain informed consent for the brain viability exam under these facts.[9]

The district court had no lawful power to grant the temporary injunction. Defendants note that the district court failed to make the findings necessary to grant a temporary injunction. *See St. David's Episcopal Church v. Westboro Baptist Church, Inc.*, 22 Kan.App.2d 537, 543-44 (1996) ("There are four prerequisites to obtain a temporary injunction: (1) a substantial likelihood that the movant will eventually prevail on the merits; (2) a showing that the movant will suffer irreparable injury unless the injunction issues; (3) proof that the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and (4) a showing that the injunction, if issued, will not be adverse to the public interest."). Defendants maintain, however, that the critical legal error was the district court's failure to apply and properly interpret K.S.A. 77-205. By refusing to permit Dr. Smith and Brett's other physicians to conduct an evaluation that was medically indicated – and necessary and appurtenant to their duty under the law to determine if Brett was legally dead – and instead ordering the physicians and other medical care providers to continue life support and all medical care, the district court exceeded its power.

III. A physician has no duty to obtain the informed consent of a minor patient's parents or guardians before the physician conducts the examinations and tests required by accepted medical standards to formally determine whether the minor patient is brain dead.

The present dispute began when the Plaintiffs refused to consent to the formal evaluation required to determine whether Brett was brain dead. Brett's physicians clearly

[9] *See* section III, *infra*.

did not know what to do when Brett's parents refused to allow the testing formally required by accepted medical standards to determine whether Brett was brain dead.[10] Defendants urge this Court to clarify that a medical provider has no legal duty to obtain the informed consent of a minor patient's parent or guardian in order to conduct the examinations necessary to determine the presence of brain death in the minor patient.

A. Standard of Review

The existence of a duty is a question of law, subject to unlimited review by this court. *Colombel v. Milan*, 24 Kan.App.2d 728, 730 (1998).

B. The law of informed consent

In *Natanson v. Kline*, 186 Kan. 393 (1960), our Supreme Court addressed the philosophic foundations of the law of informed consent:

> Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment.

Id. at 406-07; *see also*, *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y.1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation on a patient without his consent commits an assault . . .") (Cardozo, J.).

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[10] Dr. Grundmeyer, the neurosurgeon who conducted a consultative evaluation of Brett at Dr. Smith's request, was asked the following question by the district court: "when a patient refuses some confirmatory study that you wanted to run to confirm your clinical diagnosis what do you do or does that not occur?" Dr. Grundmeyer answered: "It depends on the situation. I think we all become very uncomfortable when we honestly feel something is the right thing to do and the recommendations aren't taken. I don't know what you can do." (R.Vol. V at 39).

The legal constraints against medical or surgical treatment of a minor without parental or guardian consent derive from principles of liability applicable to health care providers. In other words, neither statutory nor common law *per se* prohibit a health care provider from treating a minor without parental or guardian consent. However, common law doctrines of liability for unauthorized treatment of minors have the effect of deterring health care professionals from providing medical or surgical services to minors without the consent of a parent or guardian. Kan. Atty. Gen. Op. No. 91-43 (citing 61 Am.Jur.2d *Physicians and Surgeons*, § 178 (1981)).

It is the settled general rule in Kansas that in the absence of an emergency or unanticipated conditions arising during surgery, a physician or surgeon –before treating or operating – must obtain the consent of the patient, or if the patient is incompetent, the consent must be obtained from someone legally authorized to give it for him. *Younts v. St. Francis Hospital and School of Nursing, Inc.*, 205 Kan. 292, 298 (1970). A surgical operation on the body of a person is a technical battery or trespass, regardless of its result, unless the person or some authorized person consents to it. *Younts*, 205 Kan. at 298.

The consent of a patient, to be sufficient for the purpose of authorizing a particular surgical procedure, must be an informed consent. *Id.* at 298-99. The patient must have reasonable knowledge of the nature of the surgery and some understanding of the risks involved and the possible results to be anticipated. *Id.* at 299. This does not mean that a doctor is under an obligation to describe in detail all the possible consequences of a treatment. *Id.* Where the patient fully appreciates the danger involved, the failure of a physician in his duty to make a reasonable disclosure to the patient would have no causal relation to the injury. *Id.* In such event, the consent of the

patient to the proposed treatment is an informed consent. *Id.* The burden of proof rests throughout the trial of the case upon the patient who seeks to recover in a malpractice action for her injury. *Id.*

For there to be liability of a physician for nondisclosure, the unrevealed risk must materialize, and there must be harm to the patient; there must be a causal relationship between the physician's failure to adequately divulge information and damage to the patient. *Bartal v. Brower*, 268 Kan. 195, 201-202 (1999). A causal connection exists between the physician's nondisclosure to the patient and the patient's damage when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. *Id.* at 202. If adequate disclosure could reasonably be expected to have caused the patient to decline the treatment or medical procedure had the patient been informed to the kind of risk or danger which resulted in her harm, causation is shown but otherwise not, and the patient's testimony is relevant on such issue, but should not be controlling. *Id.*

C. The parental right to direct and consent to medical care on behalf of a minor patient

In Kansas, any parent is legally authorized to consent to medical treatment for his or her minor child. K.S.A. 38-122. The right of parental decision-making on behalf of children, including medical decision-making, is also well grounded in both common law and constitutional jurisprudence. Massie, "Withdrawal of Treatment for Minors in a Persistent Vegetative State: Parents Should Decide," 35 Ariz.L.Rev. 173, 180 (1993). Indeed, it is the declared public policy of the state of Kansas "that parents shall retain the fundamental right to exercise primary control over the care and upbringing of their

children in their charge...". K.S.A. 38-141(b). Kansas statutory law even provides for a cause of action based on this principle. K.S.A. 38-141(d).

As the United States Supreme Court explained in *Parham v. J.R.*, 442 U.S. 584 (1979),

> Our jurisprudence has historically reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. Our cases have consistently followed that course; our constitutional system long ago rejected any notion that a child is "the mere creature of the State" and, on the contrary, asserted that parents generally "have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations." . . . **Surely, this includes a "high duty" to recognize symptoms of illness and to seek and follow medical advice.** The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children.

442 U.S. at 602 (emphasis added). The court then continued, setting forth the ways in which this "presumption" might be overcome.

> As with so many other legal presumptions, experience and reality may rebut what the law accepts as a starting point; the incidence of child neglect and abuse cases attests to this. That some parents "may at times be acting against the interests of their children" . . . creates a basis for caution, but is hardly reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests.

442 U.S. at 602-03. The *Parham* court specifically considered the constitutionality of a Georgia statute that permitted parents to commit their minor children to state mental hospitals under voluntary commitment procedures. The court upheld the statute, but concluded that,

> the child's rights and the nature of the commitment decision are such that **parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized.** They, of course, retain

> plenary authority to seek such care for their children, **subject to a physician's independent examination and medical judgment.**

442 U.S. at 604 (emphasis added). Thus, although parents have a right to make the commitment decision on behalf of their minor children, they may do so only so long as the decision is sustainable on medical grounds. *See* Massie, 35 Ariz.L.Rev. at 187. This has led one commentator to note that "the constitutionally protected right of parents to make decisions concerning the welfare of their children is not unlimited and may well be subject to greater restriction in the field of medical decision-making than in any other area." *Id.* at 188.

> In individual cases, a court may order medical treatment to which parents have refused consent, and a finding of abuse or neglect, including failure to obtain appropriate medical care for a child, will invariably justify state intervention. Chief Justice Burger's opinion in Parham v. J.R. took account of these premises, and nonetheless found that, unless the individual case presented an instance of abuse **or of medically unsound judgment**, parental decision-making was to be respected.

Id (emphasis added).

Finally, the *Parham* court recognized the state's "significant interest in confining the use of its costly mental health facilities to cases of genuine need." 442 U.S. at 604-05.

D. Brett's physicians, including Dr. Smith, had no legal duty to obtain the informed consent of Brett's parents in order to perform the testing necessary to determine whether Brett was brain dead.

While Brett's medical care providers may have had a duty to keep Brett's parents fully informed on Brett's medical status, *see Dority*, 145 Cal.App.3d at 279-80; *Alvarado*, 547 N.Y.S.2d at 197-98, no legal duty existed which required the medical

providers to obtain the parents' informed *consent* to perform the evaluation and testing necessary to determine whether Brett was legally dead.

1. The rationale and language of informed consent law has no logical application to the particular facts of this case.

The law of informed consent has no logical application to a situation, such as presented by this case, where a patient's physicians recommend the need to perform testing needed to determine whether the patient is brain dead.

First, the law has forever held that the determination of when death has occurred is within the exclusive province of the medical profession.

Second, neither a court, nor a lay person, is qualified to diagnose brain death. Only the medical profession is appropriately qualified.

Third, the classical liberal assumptions underlying informed consent doctrine, i.e., the right of each person to the ownership of his or her own body,[11] mean that the doctrine does not so easily fit into the context where diagnostic testing is needed to determine whether the person is dead. If for instance, (1) a minor patient is suspected by his physicians to be dead, (2) his parents refuse to permit tests that will allow a formal determination as to whether he is dead, (3) he is *in fact* dead, but (4) the law imposes a duty on the physicians to obtain a parent's informed consent, which they refuse to give, then the law has allowed the truly absurd result that a dead child cannot legally be declared dead, because of the parents' right to control the upbringing of their child. Brett's parents' refusal to consent to the definitive testing required to confirm their opinion of brain death is akin to not allowing a physician to put a stethoscope to a

[11] In the case of an infant patient, such as this, the liberty interest at stake may more properly be stated as the right of the parents to direct the upbringing of their child.

patient's chest to determine that the heart has stopped beating. There is a difference between a risky surgical procedure and tests used to determine whether a patient is dead. The personal dignity and liberty interests – and in the case of a minor patient, parental interests – at stake in these respective situations are sufficiently disparate for the law to take notice.

Indeed, the weak logical connection between the foundational assumptions of informed consent doctrine and the facts of the present case becomes apparent when one examines the contours of the right to give informed consent as articulated by case law.

The focus informed consent cases put on revealing the "risks" or "dangers" of a particular treatment, along with disclosing the "results" or "consequences," do not fit well when the procedure is diagnostic or evaluative in nature. *Cf. Younts*, 205 Kan. at 299. Here, the testing required to determine whether Brett was brain dead involved only minimally invasive procedures and presented no danger to Brett. (R.Vol. V at 30-31, 67).

Furthermore, one of the primary purposes behind the law's imposition of a duty to obtain informed consent is to make sure a patient is fully informed before making a treatment or surgical decision. *See Younts*, 205 Kan. at 298-99 ("The consent of a patient to be sufficient for the purpose of authorizing a particular surgical procedure must be an informed consent."). This rationale does not apply when a physician proposes a "procedure" which is diagnostic and informative in nature.

Here, Dr. Smith needed to do the brain viability exam precisely because he felt that he and Brett's parent's *lacked* needed information, (*see* R.Vol. V at 46). Brett's parents did not want the information the brain viability exam would yield because they were afraid of what it *might* show – that Brett was in fact brain dead. The consequences

Brett's parents sough to avoid were legal consequences, not medical consequences. The duty to obtain informed consent has no rational application where the decision-maker does not want information a certain test would yield.

The particular diagnostic test to determine the presence of brain death is unique, however, in that certain consequences *must* follow if the testing results in a declaration of death. Hospitals and physicians must be permitted to discontinue care to patients determined to be brain dead in accordance with accepted medical standards. Thus, the issue in this case can fairly be stated to be, "Do the parents of an infant patient have the right to prevent the physicians from declaring death?" Despite the heart rending circumstances of this case, reason, common sense, and the law dictate that this Court answer, "No."

2. **Brett's parents' right to consent to, and thereby direct, Brett's medical care is, in this instance, outweighed by the medical profession's interest in its ethical integrity and the public's interest in being able to determine when patients are legally dead.**

The United States Supreme Court has recognized that a parent's right to direct the medical treatment of a minor patient is not absolute. *See Parham*, 442 U.S. at 602-03. With regard to a parent's decision to voluntarily commit a child to a mental hospital, "parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized"; their authority is "subject to a physician's independent examination and medical judgment." *Id.* at 604. Indeed, the parental right to direct the care and upbringing of a child is at its weakest when in contradiction with medical advice. *See* Massie, 35 Ariz.L.Rev. at 187-88.

The particular facts of this case present the Court with a situation where other compelling interests outweigh Brett's parents' right to direct his medical care. Medical professionals have a strong interest in protecting the integrity of their profession. Physicians and nurses have an ethical obligation to save lives. Enormous time and resources are spent administering life support care to a brain-dead infant. Physicians and nurses simply do not treat dead patients. It is thus imperative for them to have the authority to determine which patients are alive, and which have died. The law has always granted the medical profession this authority. *See* K.S.A. 77-205; *Dority*, 145 Cal.App.3d at 280; *Bowman*, 617 P.2d at 732; *Alvarado*, 547 N.Y.S. at 198; *Petition of Jones*, 433 N.Y.S.2d at 986; *Long Island Jewish Medical Center*, 641 N.Y.S.2d at 991. This Court should therefore hold that the authority to conduct the tests necessary to determine whether a patient is dead is implied as necessary and appurtenant to a physician's power to declare death.

Before the creation and recognition of the brain death standard, the "evaluation" of a patient required to determine death was much simpler. If the patient stopped breathing or his heart stopped beating and the condition was irreversible, the patient was dead. Situations similar to the one giving rise to the present case never arose.

The Washington Supreme Court set forth the reasons the brain death standard was adopted:

> Some of the specific factors compelling a more refined definition [of death] are: (1) modern medicine's technological ability to sustain life in the absence of spontaneous heart beat or respiration, (2) the advent of successful transplant capabilities which create a demand for viable organs from recently deceased donors, (3) the enormous expenditure of resources, potentially wasted if persons in fact dead are being treated medically as

> though they are alive, and (4) the need for a precise time of death so that persons who have died may be treated appropriately.

Bowman, 617 P.2d. at 734.

Similarly, each of these factors also weighs in favor of recognizing that Brett's physicians had no legal duty to obtain the informed consent of the parents before conducting an evaluation for the presence of brain death. The health care industry's (and the public's) interest in being able to determine who is dead, and who is not, outweighs any parental rights. An infant patient's physicians, not his parents, should be given the exclusive authority to determine when an evaluation to determine death is required, subject to the parents' right to be fully informed, to obtain an independent evaluation, and to have time to discuss and contemplate the results. *See Dority*, 145 Cal.App.3d at 279-80; *Alvarado*, 547 N.Y.S.2d at 197-98.

The Defendants therefore request the Court to explicitly recognize that physicians have the authority to conduct the tests necessary to determine whether their patients are dead, regardless of whether they receive consent to such testing.

CONCLUSION

This case presents issues of statewide importance capable of repetition, yet evading appellate review. As a result, this Court should not rely on the mootness doctrine to avoid rendering a decision, and should instead hear and decide this case.

The courts have always recognized that it is within the sole competence and authority of the medical profession to determine whether a patient has died, in accordance with accepted medical standards. Judicial review of a physician's determination is

limited to ensuring that the determination was in fact made according to these accepted medical standards.

The present case requires this court to decide whether the parents of an infant that physicians suspect is brain dead may block the child's physicians from even performing the evaluation required to determine brain death by seeking and obtaining the intervention of a district court. In Brett's case, three qualified physicians were of the opinion that the formal brain viability exam was necessary. Brett's parents, through the power of the district court, blocked Brett's physicians from performing their legal duty to determine whether their patient was legally dead.

For the foregoing reasons offered in this appellate brief, the Defendants respectfully request that this Court hold that the district court erred when it granted Plaintiffs' request for a temporary injunction, ordered them to continue life support and medical care as if Brett were alive, and denied Brett's physicians permission to conduct the test necessary to determine if he was legally dead.

Respectfully Submitted,

GILLILAND & HAYES, P.A.

By ____________________

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Phone: (316) 264-7321
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Attorneys for Defendants Wesley Medical Center and Dr. Smith.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 31st day of August, 2006, the original and sixteen (16) copies of the foregoing Brief of Appellants Wesley Medical Center and Lindall Smith, M.D., were shipped overnight to:

Ms. Carol Green
Clerk of the Appellate Courts
Kansas Judicial Center
301 W. 10th St.
Topeka, KS 66612-1507

with a total of two (2) copies mailed to:

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IN THE TWENTY-NINTH JUDICIAL DISTRICT COURT
WYANDOTTE COUNTY KANSAS

In the interest of Minor, Michael J. Todd)
Cecelia B. Cole, parent plaintiff,)
)
VS.)
) CASE NO. 06 CV 830
University of Kansas Medical Center)
A Corporation)
Dr. Carla Braxton, MD indivically)
Sandy LNU indivially)
Defendant)

FILED
06 MAY 12 PM 3:51
CLERK DISTRICT COURT
WYANDOTTE COUNTY KANSAS

Petition

Comes now, Cecelia B. Cole, in the interest of (son) michael J. Todd, and hereby files this PETITION. In support of this petition the plaintiff:

1. Plaintiff, Cecelia B. Cole, parent and legal guardian of Michael J Todd, a minor, is a legal resident of Kansas City, Missouri.

2. The Plaintiff incorporates by reference all information in the attached PLAINTIFF'S EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNCTION.

WHEREFORE, PLAINTIFFS request this Honorable Court to set a hearing on this Petition.

~~CERTIFICATE OF SERVICE~~

Respectfully submitted,

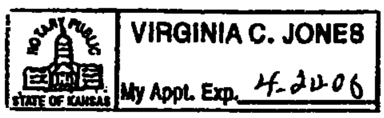
*(816) 257-7858 *
(816) 861-2615

Cecelia Cole
CECELIA B. Cole
3410 Brooklyn Avenue

CERTIFICATE OF SERVICE

I, CECELIA COLE, hereby certify that a copy of the above and foregoing PETITION in the above-styled case was served by either placing a copy of same in the United States Mail, postage prepaid or by hand delivery to the following:

THE UNIVERSITY OF KANSAS MEDICAL CENTER
DR. CARLA BRAXTON
SANDY LNU
3901 RAINBOW BOULEVARD
KANSAS CITY, KANSAS 66160



Respectfully submitted,

Cecelia Cole
CECELIA B. COLE,
Parent and Guardian
3410 BROOKLYN Avenue
KANSAS City, Missouri
64128

Subscribed and sworn to before me
This 12th day of May 2006
Notary Public: Virginia C. Jones
My Commission expires: April 20, 2008

IN THE TWENTY-NINTH JUDICIAL DISTRICT COURT
WYANDOTTE COUNTY KANSAS

FILED
06 MAY 12 PM 3:51
CLERK DISTRICT COURT WYANDOTTE COUNTY, KS

In the Interest of Minor, Michael J. Todd,)
CECELIA B. COLE, Parent)
Plaintiff,)
)
vs.)
)
University of Kansas Medical Center,)
A corporation)
Dr. Carla Braxton, MD individually,)
Sandy LNU, individually)
Defendant.)

CASE NO. 06 CV 838

PLAINTIFF'S EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNTION

COMES NOW, CECELIA B. COLE, in the interest of Michael J. Todd, and hereby files this EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNTION in the above-styled case. In Support of this Motion, the plaintiffs states as follows:

1. Plaintiff, Cecelia B. Cole, parent and legal guardian of Michael J. Todd, a minor, is a legal resident of Kansas City, Missouri.

2. Plaintiff, Michael J. Todd is a patient of the University of Kansas Medical Center in Wyandotte County, Kansas. Michael J. Todd has been a patient and under the care and control of the University of Kansas Medical Center in Wyandotte County, Kansas since May 9, 2006.

3. The Defendant, Carla Braxton, MD is a licensed physician in the State of Kansas and is the attending physician of Michael J. Todd. Carla Braxton, MD is an employee of the University of Kansas Medical Center located at 3901 Rainbow Boulevard, Kansas City, Kansas 66160.

4. The Defendant, Sandy LNU, a Registered Nurse and employee of the Kansas State University Medical Center was the on duty nurse during the evening shift in the Pediatric Neurology Unit and attended to Plaintiff.

5. On Friday, May 12, 2006, the University of Kansas Medical Center will discontinue the medical treatment Plaintiff is receiving due to a gun shot wound to his neck and will take him off of all the support ~~providing~~ provided by the medical equipment and staff of the hospital.

6. Based on the reports, personally received from Dr. Carla Braxton and documented as showing May 10, 2006 at 11:59 A.M., Dr. Carla Braxton determined that Plaintiff was "brain dead" based upon the "Nuclear Medicine Criteria for Brain Death." This finding was made without sufficient and accurate testing being conducted

7. The Plaintiffs have indicated to Dr. Braxton, medical assistants, nurses and others that the Plaintiff has responded to touch of both of his feet which he responded by both his toes. He has also responded by shedding tears and attempting to open his right eye. Plaintiff has also attempted to grip the hands of those who hold his hands.

8. These signs have all been shown **after** Dr. Braxton, incorrectly diagnosed him as being brain dead.

9. Plaintiff's mother and other family members have been informed that Plaintiff has been sedated with pain medication called, Fentanyl, a narcotic used for anesthesia.

10. Based upon conversation with Melissa, an attending nurse responsible for the care of Plaintiff on Thursday, May 10, 2006, Plaintiff's were informed that Plaintiff Todd received two dosages of Fentanyl on May 10, 2006. At 3:00 A.M., he received 50 micrograms of Fentanyl and at 4:00 A.M. he received an additional 50 micrograms of Fentanyl.

11. According to medical studies, it takes at least two to three (2-3) hours for any dosage to wear off. Because Plaintiff was heavily sedated with this potent drug and was not given adequate time for the drug to wear off, based upon the "European Association of Nuclear Assessment," "interference with drugs acting on cerebral blood flow" is a "Source of Error."

12. Also, the "European Association of Nuclear Assessment," indicates that only 7.4 - 11.1 MBq/Kg should be given to children. The minimum dosage is 110 MBq which is 3 miCi. This shows that the 100 micrograms of Fentanyl that Plaintiff received shortly before any testing was done is error.

13. Additional testing as determined by the "Uniform Determination of Death Act" in the United States, a standardize criteria indicates that a person must be "free of drugs that can suppress brain activity" and diagnosis should be made by testing using an "EGG." A "radionuclide cerebral blood flow scan" can be used as well.

14. None of these tests have been conducted when Dr. Braxton determined that Patient was "brain dead." Even if they had, the heavy diagnosis of Fentanyl would indicate that he would have the following symptoms, "trouble breathing or shallow breathing, tiredness, inability to think, talk, feeling dizzy, confused."

15. If Defendant is allowed to discontinue the medical treatment Plaintiff has been receiving in their facility on May 12, 2006, the Plaintiff will suffer irreparable injury and legal wrong.

16. The Plaintiff's have indicated to the University of Kansas Medical Center that they do not want the Plaintiff to have his medical treatment discontinued due to this diagnosis. The Plaintiff's have also indicated that they desired for Plaintiff to be transferred to Children Mercy Hospital in Kansas City, Missouri a highly respectable and reputable hospital that has experience dealing with the injuries of Plaintiff's caliber. This facility is also located in Plaintiff's place of residence.

17. The injury that will be caused by Defendants is not susceptible of compensation in damages; an adequate remedy cannot be afforded by an action for damages. Plaintiff is without an adequate remedy at law.

WHEREFORE, Plaintiffs request this Honorable Court to issue an Order directing the University of Missouri Medical Center to refrain from discontinuing the life-sustaining, nutrients, medical services, and medical equipment that has been provided to assist Plaintiff while in the care of the University of Missouri Medical Center. Plaintiff also requests that he be transferred to the Children's Mercy Hospital in Kansas City, Missouri immediately. Finally, Plaintiff requests a hearing on this **EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNTION.**

This the 12 day of May, 2006.

NOTARY PUBLIC STATE OF KANSAS VIRGINIA C. JONES My Appt. Exp. 4-20-08

Respectfully submitted,

[signature]

CECELIA B. COLE, Parent and Guardian
3410 Brooklyn Avenue
Kansas City, Missouri 64128

Subscribed and sworn to before me

This 12th day of May 2006

Notary Public: [signature]

My Commission expires: April 20. 2008

CERTIFICATE OF SERVICE

I, **CECELIA B. COLE,** hereby certify that a copy of the above and foregoing **EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNTION** in the above-styled case was served by either placing a copy of same in the United States Mail, postage prepaid or by hand delivery to the following:

THE UNIVERSITY OF KANSAS MEDICAL CENTER
Dr. Carla Braxton
Sandy LNU
3901 RAINBOW BOULEVARD
KANSAS CITY, KANSAS 66160

This 18 day of May, 2006.

Subscribed and sworn to before me
This 12th day of May 2006
Notary Public: Virginia C. Jones
My Commission expires: April 20, 2008

NOTARY PUBLIC STATE OF KANSAS | VIRGINIA C. JONES | My Appt. Exp. 4-20-08

Respectfully submitted,

Cecelia Cole

CECELIA B. COLE, Parent and Guardian
5410 Brooklyn Avenue
Kansas City, Missouri 64128

IN THE TWENTY-NINTH JUDICIAL DISTRICT COURT
WYANDOTTE COUNTY KANSAS

FILED
06 MAY 12 PM 4:15
CLERK DISTRICT COURT
WYANDOTTE COUNTY KANSAS

CECELIA B. COLE, in the interest of Michael J. TODD, a MINOR)

CASE NO. 2006-CV-00683

VS.

University of Kansas Medical Center
A Corporation
Dr. Carla Braxton, MD individually
Sandy LNU individilly

Defendants

I hereby certify the above and foregoing to be a True and correct copy, the original of which is filed and entered record in this court.
CLERK DISTRICT COURT
WYANDOTTE CO, KS
DATE 8-23-06
by A Bowers, deputy.

Temporary ORDER

Having Considered the Plaintiff motion on May 12th 2006, the court enters it's order granting plaintiff incorporates by reference al information in the attached PLAINTIFF'S Emergency Motion FOR Temporary Restraining order and motion for Preliminary injunction This ~~Under~~ ___ May, 2006 [signature]

ISSUED 6 SUBP. TO ATTY
5/19/06

IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS

FILED
06 MAY 19 AM 8:03
CLERK DISTRICT COURT
WYANDOTTE COUNTY, KS

In the Interest of Minor Michael J. Todd, **CECELIA B. COLE, Parent,**	)	
Plaintiff,	)	
v.	)	**Case No.: 06 CV 00830** **Division No. 2**
UNIVERSITY OF KANSAS MEDICAL CENTER, et al.,	)	
Defendants.	)	

REQUEST AND INSTRUCTION FORM

The Clerk of the Court will issue a Subpoena in the above-entitled action for: Michael Moncure, M.D.; Carla Braxton, M.D.; Andreas Deymann, M.D.; Gary Gronseth, M.D.; Reginald Dusing; and Gigi Reed. You are hereby instructed to effect service as follows:

____ a. Service through the office of the Sheriff of Wyandotte County, State of Kansas, other than by certified mail.

_X_ b. Service by a Process Server Authorized or appointed by the provisions of K.S.A. § 60-303(c)(3).

____ c. Certified mail service by the undersigned litigant/ attorney, who understands that the responsibility for obtaining service and effecting its return shall be on the attorney. The receipt for service (green card) must be filed with the clerk's office before service can be perfected.

____ d. Certified mail service by the Office of the Sheriff of Wyandotte County, State of Kansas. The undersigned understands that the responsibility for obtaining service and effecting its return shall be on the Sheriff.

Respectfully submitted,

POLSINELLI SHALTON WELTE SUELTHAUS PC

By: ______________________

TIMOTHY J. SEAR (#14813)
MARY BETH BLAKE (#09470)
MISHCA L. WALICZEK (#19223)
6201 College Boulevard, Suite 500
Overland Park, Kansas 66211
(913) 451-8788
Fax No. (913) 451-6205

ATTORNEYS FOR DEFENDANT
UNIVERSITY OF KANSAS HOSPITAL AUTHORITY

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the above and foregoing pleading was served by (X) U.S. Mail, postage prepaid; (____) fax; (____) Federal Express; and/or (____) hand delivery this 19th day of May 2006, to:

Joel Oster
Kevin Theriot
David LaPlante
Alliance Defense Fund
15192 Rosewood
Leawood, KS 66224

ATTORNEYS FOR PLAINTIFF

____

023186 / 043985
JALOW 248436

IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS

BY FAX

In the Interest of Minor Michael J. Todd, CECELIA B. COLE, Parent,

Plaintiff,

v.

University of Kansas Medical Center, et al.,

Defendants.

Case No.: 06 CV 00830

DEFENDANT UNIVERSITY OF KANSAS HOSPITAL AUTHORITY'S ANSWER, AFFIRMATIVE DEFENSES, AND COUNTERCLAIMS TO PLAINTIFF'S PETITION AND EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND MOTION FOR PRELIMINARY INJUNCTION

COMES NOW Defendant University of Kansas Hospital Authority, referred to in the caption as the University of Kansas Medical Center, ("UKHA"), and for its answer, affirmative defenses, and counterclaims to Plaintiff's Petition and Emergency Motion for Temporary Restraining Order and Motion for Preliminary Injunction ("Motion"), states as follows:

UKHA'S ANSWER TO THE ALLEGATIONS CONTAINED IN THE PETITION

1. UKHA admits the allegations contained in paragraph 1 of the Petition.

2. Because Plaintiff incorporated the Motion into the Petition, for its answer to the allegations in paragraph 2 of the Petition, UKHA hereby incorporates by reference its Response to the Allegations Contained in the Motion.

UKHA'S RESPONSE TO THE ALLEGATIONS CONTAINED IN THE MOTION

1. UKHA admits the allegations contained in paragraph 1 of the Motion.

2. UKHA admits that Michael J. Todd was admitted to the University of Kansas Hospital in Wyandotte County, Kansas, on May 9, 2006, and remains in the care of the

University of Kansas Hospital. UKHA denies the remainder of the allegations contained in paragraph 2 of the Motion.

3. UKHA denies that Dr. Carla Braxton is the current attending physician of Michael J. Todd, that Dr. Braxton was the attending physician of Michael J. Todd as of the filing of the Motion, and that Dr. Braxton is an employee of UKHA. UKHA admits the remainder of the allegations contained in paragraph 3 of the Motion.

4. UKHA is without sufficient information to admit or deny the allegations contained in paragraph 4 of the Motion.

5. UKHA denies the allegations contained in paragraph 5 of the Motion.

6. UKHA admits that Dr. Braxton confirmed Michael J. Todd's brain death by exam and nuclear medicine study and noted same in his medical chart on May 10, 2006. UKHA denies the remainder of the allegations contained in paragraph 6 of the Motion.

7. UKHA is without sufficient information to admit or deny the allegations contained in paragraph 7 of the Motion.

8. UKHA denies the allegations in paragraph 8 of the Motion.

9. UKHA is without sufficient information to admit or deny the allegations contained in paragraph 9 of the Motion.

10. UKHA is without sufficient information to admit or deny the allegations contained in paragraph 10 of the Motion.

11. To the extent the documents referred to in paragraph 11 of the Motion exist, UKHA states that those documents speak for themselves and respectfully refers the Court to those documents for the contents contained therein. Because the remainder of the allegations

contained in paragraph 11 of the Motion state legal conclusions, UKHA therefore denies the same.

12. To the extent the document referred to in paragraph 12 of the Motion exists, UKHA states that the document speaks for itself and respectfully refers the Court to that document for the contents contained therein. Because the remainder of the allegations contained in paragraph 12 of the Motion state legal conclusions, UKHA therefore denies the same.

13. To the extent the document referred to in paragraph 13 of the Motion exists, UKHA states that the document speaks for itself and respectfully refers the Court to that document for the contents contained therein. Because the remainder of the allegations contained in paragraph 13 of the Motion state legal conclusions, UKHA therefore denies the same.

14. UKHA denies the allegations contained in paragraph 14 of the Motion.

15. UKHA denies the allegations contained in paragraph 15 of the Motion.

16. UKHA admits that Plaintiff has requested that the University of Kansas Hospital not discontinue treatment of Michael J. Todd and that Todd be transferred to Children's Mercy Hospital in Kansas City, Missouri. UKHA denies the remainder of the allegations in paragraph 16 of the Motion.

17. UKHA denies the allegations contained in paragraph 17 of the Motion.

GENERAL DENIAL

UKHA denies each and every allegation in the Petition and the Motion not specifically admitted herein.

AFFIRMATIVE DEFENSES

FIRST AFFIRMATIVE DEFENSE

The Petition and the Motion fail to state a claim against UKHA upon which relief may be granted.

SECOND AFFIRMATIVE DEFENSE

Plaintiffs are not in imminent danger of suffering harm as a result of UKHA's acts or omissions.

THIRD AFFIRMATIVE DEFENSE

UKHA reserves the right to assert any other defenses or matters in avoidance of Plaintiff's claims which may become appropriate as discovery proceeds in this case.

WHEREFORE, having fully answered the allegations in Plaintiff's Petition and Emergency Motion for Temporary Restraining Order and Motion for Preliminary Injunction, Defendant University of Kansas Hospital Authority, referred to in the caption as University of Kansas Medical Center, prays that Plaintiff's Petition and Motion be dismissed in the entirety and that Defendant University of Kansas Hospital Authority be granted costs incurred, including attorneys' fees, and such other relief as is just and proper.

DEFENDANT UNIVERSITY OF KANSAS HOSPITAL AUTHORITY'S COUNTERCLAIM FOR DECLARATORY JUDGMENT CONFIRMING DEFENDANT'S DETERMINATION OF DEATH AND REQUEST FOR HEARING

Defendant-Counterclaim Plaintiff University of Kansas Hospital Authority ("UKHA"), as and for its counterclaims against Plaintiff-Counterclaim Defendant Cecilia B. Cole, in the interest of Minor Michael J. Todd ("Plaintiff"), states and alleges as follows:

PARTIES

1. Pursuant to K.S.A. § 76-3301 *et seq.*, UKHA is a body politic and independent instrumentality of the State of Kansas. UKHA operates the University of Kansas Hospital.

2. Plaintiff is a resident of Kansas City, Missouri, and is the parent and legal guardian of Michael J. Todd ("Todd"), a minor.

3. Pursuant to K.S.A. § 60-1701, this court has jurisdiction to declare the rights, status, and other legal relations of the parties.

4. Pursuant to K.S.A. § 60-605(1), venue is proper in this Court.

FACTS COMMON TO ALL COUNTS

5. On or about May 9, 2006, Todd was involved in an accident and suffered a gunshot wound to the neck.

6. On or about May 9, 2006 Todd was seen in the emergency room at St. Mary's Medical Center in Blue Springs, Missouri.

7. That same day, Todd was transferred to the University of Kansas Hospital.

8. On May 10, 2006, qualified physicians at the University of Kansas Hospital made a clinical determination that Todd was brain dead, and confirmed that determination through diagnostic tests.

9. The diagnosis was made pursuant to the recognized standard of care and consistent with University of Kansas Hospital Ethics Handbook Procedures for Determining Brain Death.

10. The diagnosis has been confirmed by a pediatric neurologist, a pediatric intensivist and a pediatric neurosurgeon.

11. Despite the diagnosis of Todd's brain death, no order has been issued to remove mechanical ventilation.

COUNT I - DECLARATORY JUDGMENT
CONFIRMING UKHA'S DETERMINATION OF DEATH

For Count I of its Counterclaim against Plaintiff, UKHA states and alleges as follows:

12. UKHA hereby adopts and incorporates by reference the allegations contained in paragraphs 1 through 10, as though fully set forth herein.

13. Pursuant to K.S.A. § 77-205:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

14. Todd's condition meets the definition of death as stated in K.S.A. § 77-205(2).

15. UKHA made its determination of death in accordance with accepted medical standards.

16. Nonetheless, Plaintiff has alleged that UKHA made an improper determination that Todd is brain dead.

17. UKHA now seeks a confirmation from this Court of UKHA's determination of brain death and that Todd is legally dead.

WHEREFORE, Counterclaim-Plaintiff University of Kansas Hospital Authority respectfully requests that this Court enter its Order confirming the determination of Michael J. Todd's brain death and legal status as dead pursuant to the laws of the State of Kansas, and for such other and further relief as this Court deems necessary and appropriate.

COUNT II – DECLARATORY JUDGMENT THAT UKHA CAN CEASE
MEDICAL TREATMENT OF MICHAEL J. TODD

For Count II of its Counterclaim against Plaintiff, UKHA states and alleges as follows:

18. UKHA hereby adopts and incorporates by reference the allegations contained in paragraphs 1 through 17, as though fully set forth herein.

19. Pursuant to the University of Kansas Hospital Ethics Handbook Procedures for Determining Brain Death, once death is declared, the patient's family is not asked to participate in or make the decision that the patient is brain dead, and treatment of the patient should cease.

20. Nonetheless, in Todd's case, UKHA has respected Plaintiff's request to continue medical treatment of Todd, despite the fact that he has been declared brain dead.

21. UKHA now seeks a declaration from this Court that, in light of the fact that Todd is legally dead, UKHA is not required to continue providing medical treatment to Todd.

WHEREFORE, Counterclaim-Plaintiff University of Kansas Hospital Authority respectfully requests that this Court enter its Order confirming that, due to Michael J. Todd's brain death and legal status as dead pursuant to the laws of the State of Kansas, the University of Kansas Hospital Authority may cease providing medical treatment to Michael J. Todd, and for such other and further relief as this Court deems necessary and appropriate.

REQUEST FOR HEARING

Pursuant to K.S.A. 60-257, the court may order a "speedy hearing" on this matter. UKHA thus requests that this Court set the matter for hearing as soon as is reasonably practicable.

Respectfully submitted,

POLSINELLI SHALTON WELTE SUELTHAUS PC

By: ______________________________

TIMOTHY J. SEAR (#14813)
MARY BETH BLAKE (#09470)
6201 College Boulevard, Suite 500
Overland Park, Kansas 66211
(913) 451-8788
Fax No. (913) 451-6205
ATTORNEYS FOR DEFENDANT
UNIVERSITY OF KANSAS HOSPITAL AUTHORITY

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the above and foregoing pleading was served by (____) U.S. Mail, postage prepaid; (____) fax; (____) Federal Express; and/or (__X__) hand delivery this 15th day of May 2006, to:

Cecelia B. Cole
3410 Brooklyn Avenue
Kansas City, Missouri 64128
PLAINTIFF *PRO SE*

____

023186 / 043985
LETUC 1344894

FACSIMILE TRANSMISSION COVER SHEET

DATE: May 15, 2006

TO: Clerk of the District Court
In the District Court of Wyandotte County, Kansas

FAX: (913) 573-4134

CASE NUMBER: 06CV830

CAPTION: IN THE INTEREST OF MINOR MICHAEL J. TODD,
CECELIA B. COLE, PARENT,
Plaintiff

v.

UNIVERSITY OF KANSAS MEDICAL CENTER, et al.
Defendant.

FROM: TIMOTHY J. SEAR (#14813)
MARY BETH BLAKE (#09470)
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(913) 451-8788
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ATTORNEYS FOR DEFENDANT

PLEASE FILE THE FOLLOWING:

	Document Name	Number of Pages
1.	Defendant University of Kansas Hospital Authority's Answer, Affirmative Defenses, and Counterclaims to Plaintiff's Petition and Emergency Motion for Temporary Restraining Order and Motion for Preliminary Injunction	8

FILED
2006 JUN 14 PM 1:46
CLERK DISTRICT COURT
WYANDOTTE COUNTY KANSAS
BY DEPUTY

IN THE DISTRICT COURT OF WYANDOTTE COUNTY, KANSAS

In the Interest of Minor Michael J. Todd,
CECELIA B. COLE, Parent,

Plaintiff,

v.

UNIVERSITY OF KANSAS MEDICAL CENTER, et al.,

Defendants.

Case No.: 06 CV 00830
Division No. 2

ORDER DISSOLVING TEMPORARY RESTRAINING ORDER

On May 19, 2006, the Court conducted, with the consent of counsel, a telephonic hearing Plaintiff appeared by Joel Oster. Defendant University of Kansas Hospital Authority appeared by Timothy J. Sear At that time, the Court was advised that a neurologist retained by Plaintiff had reviewed the medical charts and examined Michael J Todd and concurred in the determination of brain death from May 10, 2006

Based upon the foregoing, the Court ordered that the Temporary Restraining Order entered on May 12, 2006 was and is DISSOLVED effective as of 3:40 pm on May 19, 2006 and that the attending physicians may withdraw medical care.

IT IS SO ORDERED.

DISTRICT JUDGE

I hereby certify the above and foregoing to be a True and correct copy, the original of which is filed and entered record in this court.
CLERK DISTRICT COURT
WYANDOTTE CO, KS
DATE 8-23-06
by L Bowers, deputy.

Submitted by:

By:____________________________

JOEL OSTER (#18547)
KEVIN THERIOT (#21565)
DAVID LAPLANTE (#22226
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Leawood, KS 66224

ATTORNEYS FOR PLAINTIFF

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By:____________________________

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Mom fights for son's life support

BY DAVID TWIDDY
Associated Press

KANSAS CITY, Kan. — The mother of a 14-year-old gunshot victim now in the middle of a legal fight over whether he's medically dead said she's not backing down in her battle to keep a hospital from taking him off life support.

But Cecelia B. Cole also said the University of Kansas Hospital just wants to harvest her son's organs.

"You can't twist my arm and make me pull the plug on my son," Cole said Tuesday. "There's always hope."

Lawyers for the hospital are expected to appear before a Wyandotte County district judge Wednesday to ask that she declare Michael Todd medically dead and remove a restraining order now preventing the hospital from disconnecting the boy from life support systems.

A bullet struck Michael in the neck during what witnesses say was an accidental shooting on May 9 in Blue Springs, Mo.

In court documents, the hospital said a pediatric neurologist, an intensive-care specialist and a neurosurgeon confirmed the diagnosis of Michael's attending physician that the boy is brain dead. Brain death is defined as the complete and irreversible ceasing of brain activity, even in the brain stem.

Cole, however, got a judge to keep the machines running, claiming that her son has shown signs of independent brain activity, including crying, attempting to open one of his eyes and trying to grasp the hands of people who hold his hands. She also said hospital staff didn't wait for sedatives to wear off before testing her son's brain function.

Additionally, Michael's family argues that the hospital wants to remove the boy from life support because it wants to use his organs for a donor program. Cole said doctors approached her about harvesting the organs even before declaring her son brain dead.

"I would have to call it intentional," she said of the hospital's treatment of her and her son. "Once I've said . . . don't continue it (pressure to turn off the machines), and you continue it, then you're intentional."

The hospital insists it follows state-mandated regulations for determining brain death and that it wouldn't necessarily benefit from Michael's organs.

"You do not sell organs. They're donated," spokesman Dennis McCulloch said.

Wichita balks at wireless network

BY FRED MANN
The Wichita Eagle

The city of Wichita decided Tuesday not to become part of a wireless data network linking it technologically with Sedgwick County, the Wichita school district and Westar Energy.

City Council members said they were worried that the system would be out of date by the time it's installed, and that it would compete with private industry.

four partners, not the public. It was designed to provide technology for data, voice, video and vehicle location functions for the partners.

The city was to bear the burden of upfront costs among the four entities, putting up $672,879 in matching funds for the federal grants.

"I'm extremely uncomfortable with the cost-benefit of doing this," council member Sue Schlapp said. "It seems to be an awful lot of money for right now for something we're

nologies. By the time we get it in it's outdated," council member Carl Brewer said.

Council member Paul Gray said the costs of the hardware required to make the system work hadn't been calculated. He said the city could reach agreements with local providers if it wants such a system.

Sedgwick County commissioners are scheduled to discuss the issue at their weekly meeting today, but may defer it, county spokeswoman Kristi Zukovich said.

BILL

From Page 1B

passed both chambers by wide margins.

Doug Anstaett, executive director of the Kansas Press Association, said the maneuver blocked public input.

"This blatant disregard for the people's right to participate in the political process is enough on its own to send this legislation back for further consideration," he said in a letter urging Sebelius to veto the bill.

No permits are likely to be issued until January, when lawmakers return for the 2007 session.

Another controversial bill, also passed on the final day of the session, contained provisions of 12 separate bills addressing advance voting procedures and campaign finance changes.

One provision, which had passed neither chamber, increased the amount of money legislative candidates can receive from a contributor in each primary and general election cycle.

"Obviously, there was not public testimony on many of those issues," said Rep. Jo Ann Pottorff, R-Wichita.

Legislators also attempted, but failed, to bundle bills allowing private prisons, which a majority of the House opposed, with tougher sentences for sex predators and other criminals.

Nicole Corcoran, Sebelius' spokeswoman, said the governor has made no decision on whether to sign the gun bill that spells out how permits will be issued.

"We have received both letters in support and against this

Park, tried to get the bill sen
back for more negotiation o
the final day of the session.
"If my neighbor's packing
like to know about it," he sa
The chief Senate sponsor,
Republican Phil Journey of
Haysville, had agreed to pul
release of names and count
residence for permit holder
but not addresses or Social
Security numbers. The bill
passed the Senate with that
vision.
The House rejected that v
sion.
"I knew that was controv
sial, and it hadn't had a hea
ing," Journey said. "I also k
we needed all the nuts and
bolts, and we could deal wi
confidentiality next year."
Names of people whose p
mits are revoked for violati
the gun law would become
lic record under the final ve
sion that passed.
Another provision creates
database of people who hav
been involuntarily committ
by a judge for mental healt
treatment. They would be
barred from obtaining gun
mits.
Rich Gannon, lobbyist for
Kansas Press Association, s
making the list of all permi
holders public would give p
ple a chance to alert local s
iffs to people with mental il
ness who have not been
ordered into treatment.
"I would think this would
something the general publ
would have a great interest
he said.

NEWS 2 USE
Every Day on 2A

KansasCity.com

Posted on Wed, May. 17, 2006

Hopeful, she wants another diagnosis

Mom senses son declared brain dead is slipping away VIDEO

By ROBERT A. CRONKLETON
The Kansas City Star

The Kansas City mother of a 14-year-old boy declared brain dead a week ago does not want to give up hope but expressed doubt Tuesday that her son would survive.

Outside the Wyandotte County Courthouse, Cecelia B. Cole said she felt her son, Michael J. Todd, was slipping away, but she wanted an independent diagnosis.

Asked how Michael was doing, Cole responded: "He is doing poorly. I think he has expired."

Cole filed for a restraining order Friday on behalf of her son, who had been shot in the neck May 9 in Blue Springs, apparently by accident. She wanted to make sure the University of Kansas Hospital did not stop treatment.

"What I would like them to do now is for some unbiased doctor to go through some natural or regular procedures of announcing a person dead," Cole said.

A doctor from Children's Mercy Hospital did examine the boy Friday, said Tom McCormally, public information officer for Children's Mercy Hospitals and Clinics. He declined to discuss the results because of federal privacy laws.

In her request for the restraining order, Cole had asked that the University of Kansas Hospital transfer her son to Children's Mercy. The University of Kansas Hospital tried to comply with her request, said Dennis McCulloch, the hospital's director of public and government relations. But to make the transfer, he said, the receiving hospital must agree.

Children's Mercy accepts any patient that it believes it can help, McCormally said. When asked why the hospital did not accept Michael, McCormally repeated the policy, saying privacy laws prevented him from going into further detail.

Physicians at the University of Kansas Hospital diagnosed Michael as brain dead last Wednesday and confirmed that through diagnostic tests, according to a response the hospital filed Monday.

The hospital asked the court to declare the boy dead and rule that the hospital not be required to continue medical treatment. The hospital also wants the restraining order dismissed.

Cole had taken issue with the determination of brain death, claiming that her son showed signs of life afterward.

"I don't know if he is brain dead," she said Tuesday, adding that more diagnostic tests should have been done.

An attorney for the University of Kansas Hospital is expected meet at 9:45 a.m. today with Wyandotte County District Judge Muriel Y. Harris.

No hearing has been set on the hospital's motion, however, and attorneys for the hospital were trying to see whether any other judge could expedite a hearing.

Attorneys had hoped to go before Harris on Tuesday, but she was not in court.

To reach Robert A. Cronkleton, call (816) 234-5994 or send e-mail to bcronkleton@kcstar.com.